CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155365		A. BUII	LDING	01	COMPL		
100000				G		05/09/	2012
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE EAST ST		
WABAS	H SKILLED CARE (CENTER		1	SH, IN 46992		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF COI			
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG K0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	BEIGER		DATE
110000						ļ	
	A Life Safety C	A Life Safety Code Recertification			Wabash Skilled Care		
	and State Licer	isure Survey was			Center		
	1	the Indiana State			ID No. 155365	ļ	
	Department of				Visit Completion Date		
	accordance wit	th 42 CFR 483.70(a).			5/9/2012		
	Cumum Datas C	NE /00 /12			ISDH Plan of Correcti	ion	
	Survey Date: 0	J3/U9/12				OII	
	Facility Numbe	er: 000256			May 25, 2012		
	Provider Numb				Preparation and/or execution of thi	is	
	AIM Number: N/A				plan of correction in general, or this		
		, ,			corrective action in particular, does	, !	
	Surveyor: Amy	/ Kelley, Life Safety			not constitute an admission or	ļ	
	Code Specialis	•			agreement by this facility of the facts alleged or conclusions set fort	·h	
		•			in this statement of deficiencies.		
	At this Life Safety Code survey,				The plan of correction and specific	ļ	
		Care Center was			corrective actions are prepared	ļ	
		ompliance with			and/or executed in compliance with	า	
		for Participation in			state and federal laws.	ļ	
	Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety				This plan of correction constitutes		
					our credible allegation of		
					compliance with all regulatory		
					requirements. Our date of		
					compliance is June 8, 2012.	ļ	
	· ·	Code (LSC), Chapter 19, Existing					
	Health Care Occupancies and 410						
	IAC 16.2.	·					
	This facility wa	is located on the					
	third floor of a three story						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

building with a basement

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000256

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED				
155365			B. WING		05/09/2012			
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EAST ST				
WABASI	H SKILLED CARE (CENTER	WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	determined to construction a was fully sprin will include the due to the lack separation bet. Care Center and third floor occides a fire alarm smoke detection and areas open. The facility has and had a cens of this survey. Quality Review by Code Specialist-Met. The facility was compliance with aforementione.	be of Type I (443) and the third floor klered. This survey e entire third floor of two hour ween the Skilled d the remaining upancy. The facility a system with on in the corridors a to the corridors. a capacity of 25 sus of 12 at the time Robert Booher, Life Safety dical Surveyor on 05/15/12.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01		COMPLETED				
	155365		B. WING	05/09/2012				
NAME OF B	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	710 N EAST ST					
WABASH SKILLED CARE CENTER			WABASH, IN 46992					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX TAG			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE			
K0050	NFPA 101	LSC IDENTIFY ING INFORMATION)	TAG	BEIGH, (1)	DATE			
SS=F	_	ODE STANDARD						
00 1		d at unexpected times under						
		ns, at least quarterly on each						
		s familiar with procedures						
		t drills are part of established sibility for planning and						
	-	is assigned only to						
		ons who are qualified to						
		hip. Where drills are						
		een 9 PM and 6 AM a coded						
	announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted							
			K0050	K 050 NFPA 101 LIFE SAFETY CODE	06/08/2012			
				STANDARD				
		ch shift for 2 of the		It is the intent of this facility to				
		ed quarters. This		ensure that fire drills are conducted quarterly on each shift.				
	· ·	ce could affect all		quarterly on each sinit.				
	occupants.	ce could affect all		What corrective actions will be				
	occupants.			accomplished for those residents				
	Findings includ	lo:		found to have been affected by the				
	Findings includ	le.		deficient practice?				
	Based on review	w of the "Fire Drill		The Administrator will review the				
	Summary" with	the Credential		fire drill schedule by 6/8/12 for the				
	Specialist on 05	5/09/12 from		year to ensure that a drill is				
	12:03 p.m. to 1	12:23 p.m., there		scheduled on each shift for each guarter. The facility will adhere to				
		of a third shift fire		fire drill schedule to ensure				
	drill for the thir	rd quarter of 2011		compliance.				
		ift fire drill for the						
	fourth quarter of 2011. Based on an interview with the Credential Specialist at the time of record			How will the facility identify other				
				residents having the potential to be	•			
				affected by the same deficient practice and what corrective action				
	· ·	er documentation		will be taken?				
	•	or review to verify						
	these drill were	· · · · · · · · · · · · · · · · · · ·		The alleged deficient practice had				
	Lilese ullii wele	conducted.			1			

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		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		DENTIFICATION NUMBER: A. BUII		BUILDING 01		COMPLETED	
		155365	B. WIN	G		05/09/2012	
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				710 N E	AST ST		
WABASH	I SKILLED CARE C	CENTER		WABAS	5H, IN 46992		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
					the potential to affect all residents.		
	3.1-19(b)				The Administrator will review the		
	3.1-51(c)				fire drill schedule by 6/8/12 for the		
	3.1 31(c)				year to ensure that a drill is		
					scheduled on each shift for each		
					quarter. The facility will adhere to		
					fire drill schedule to ensure		
					compliance.		
					What measures will be put into		
					place or what systemic changes wil	ı	
					be made to ensure that the		
					deficient practice does not occur?		
					The fire drill schedule will be		
					developed annually with scheduled		
					drills on each shift every quarter. If		
					there is an additional fire alarm that		
					is triggered in addition to the		
					scheduled drill, the facility will still		
					continue to follow the original		
					schedule to ensure compliance.		
					How will the corrective action be		
					monitored to ensure the deficient		
					practice does not recur?		
					The Administrator will review the		
					fire drill results monthly to ensure a		
					drill is completed on each shift		
					quarterly.		
					•		
					Quality Assurance Follow-up:		
					The fire drill records will be		
					submitted to the Quality Assurance		
					Committee quarterly for review to		
					ensure compliance.		
					Date of Compliance: June 8, 2012		
			1		Date of Compliance. Julie 6, 2012	<u> </u>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
		155365	B. WING 05/09/2012				
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF TROVIDER OR SOFTEIER					EAST ST		
WABASH SKILLED CARE CENTER			WABASH, IN 46992				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		N
TAG K0052	REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101			TAG	BLI ICILICE ()	DATE	
SS=E	LIFE SAFETY CODE STANDARD						
00 _	A fire alarm syste	em required for life safety is					
		and maintained in					
		NFPA 70 National Electrical					
		72. The system has an enance and testing program					
	complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and						
						0.5/0.0/2.04	
			K00)52	K 052 NFPA 101 LIFE SAFETY CODE STANDARD	06/08/2012	.2
	interview, the f				STANDARD		
	ensure 1 of 1 c				It is the intent of this facility to		
		rs was maintained			ensure that all smoke detectors pass	í	
	in accordance with the applicable requirements of NFPA 72, National				the sensitivity test.		
	Fire Alarm Cod	e. NFPA 72, 7–3.2			What corrective actions will be accomplished for those residents		
	requires detect	or sensitivity shall			found to have been affected by the		
	be checked wit	hin 1 year after			deficient practice?		
	installation and every alternate year thereafter. After the second required calibration test, if						
					The Simplex model 4259-35 does		
					not have a marked range and		
	sensitivity tests	s indicate the			according to NFPA 72 the range used should be 0.5% to 4.0%. The range	1	
	detector has re	emained within its			used on the report identified was		
	listed and marked sensitivity				incorrect and has been corrected.		
	range (or 4 per	cent obscuration			The Facilities Leader notified the		
	light gray smok	ce, if not marked),			Testing Company of the error on the		
	the length of time between				sensitivity range. Testing Company has corrected error on reporting		
	calibration test	s shall be permitted			system to reflect the proper		
	to be extended	to a maximum of			sensitivity range for the Simplex		
	5 years. If the	frequency is			Smoke Detector model 4259-35. The	<u>!</u>	
	extended, reco	rds of detector			device has been tested by the		
	caused nuisanc	ce alarms and			Facilities Leader with a result of 2.61%.		
	subsequent tre	nds of these alarms			2.01/0.		
	shall be mainta	ined. In zones or			How will the facility identify other		
in areas where nuisance alarms				residents having the potential to be			

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. building 01		COMPLETED		
	155365					05/09/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				710 N E	EAST ST		
WABASH	SKILLED CARE C	CENTER		WABAS	SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)		IAG	,	DATE	
	show any incre				affected by the same deficient practice and what corrective action	,	
	1 '	calibration tests			will be taken?		
	· ·	med. To ensure					
	each smoke de	tector is within its			All residents have the potential to b	e	
	listed and mar	ked sensitivity			affected by the alleged deficient		
	range, it shall l	be tested using any			practice. The Facilities Leader		
	of the following	g methods:			notified the Testing Company of the	!	
	(1) Calibrated	test method			error on sensitivity range. Testing		
	(2) Manufactui	rer ' s calibrated			Company has corrected error on reporting system to reflect the		
	sensitivity test				proper sensitivity range for the		
	(3) Listed cont				Simplex Smoke Detector model		
	arranged for th	• •			4259-35.		
	_	ector/control unit					
					What measures will be put into		
	_	hereby the detector			place or what systemic changes wil	1	
	_	l at the control unit			be made to ensure that the		
		tivity is outside its			deficient practice does not occur?		
	listed sensitivit	· · · · · ·			The Facilities Leader will check each		
		rated sensitivity test			smoke detector sensitivity log to		
	methods appro	•			ensure that each detector log has		
	authority havin				the correct information listed. This		
	Detectors foun	d to have a			will be completed by 6/8/2012.		
	sensitivity outs	side the listed and					
	marked sensiti	vity range shall be			How will the corrective action be monitored to ensure the deficient		
	cleaned and re	calibrated or be			practice does not recur?		
	replaced. This	deficient practice			practice does not recur.		
	could affect any number of				The Facilities Leader will review eac	h	
	occupants in th	ne Center stairwell.			fire system report monthly to ensur	e	
	Findings include:				compliance.		
					Quality Assurance Follow-up:		
	Based on recor	d review on			Each fire alarm system report will be	e	
	05/09/12 at 1				submitted to the Quality Assurance		
	· '	echnician # 1 of the			Committee quarterly for review.		
	manifecturies recriminally roll the					1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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155365		A. BUILDING B. WING O1 COMPLETED 05/09/2012						
NAME OF PROVIDER OR SUPPLIER WABASH SKILLED CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL C IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	Automated Logic smoke detector in "Sensitivity Testing floor smoke detector smoke detector stainwell in the sensitivity test. In the smoke with Marecord review, he provide document the smoke detector repaired or replaced in the smoke detector smo	c Corporation record titled reg", the third rector inside the failed the Based on an aintenance t the time of e was unable to ntation to show tor had been			Date of Compliance: 6/8/2012			

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